2021-22 EMPLOYEE INFLUENZA VACCINATION CONSENT FORM
INACTIVATED INFLUENZA (IIV) ONLY

Name: _____
Last First Middle

Date of Birth: ____/____/____ Age: ____ Gender: ❑ M ❑ F
Last First M.I.

SSN: ____ - ____ - ____ *optional*

Address: _____ City/State: _____ ZIP: _____

School: _____

IMPORTANT Phone # Home: _____ Cell: _____ Work: _____

Health Department Use Only
CI #: _____
Encounter #: _____
Receipt #: _____

Please check YES or NO to all of the questions below to determine if you can receive the Inactivated Influenza Vaccine ("flu shot"). The nurse giving the vaccine will review this information on the day of the vaccine clinic.

	YES	NO
1. Have you ever had a serious allergic reaction to any component of any flu vaccine (eggs, gentamicin, gelatin and arginine)?	❑	❑
2. Have you ever had a serious reaction to a previous dose of flu vaccine in the past?	❑	❑
3. Have you ever had Guillain-Barré syndrome (GBS, i.e., progressive ascending paralysis)?	❑	❑

If you answered YES to any of questions 1, 2 or 3 above about serious allergy, reaction or GBS, flu vaccine may not be safe for you and you WILL NOT receive a flu vaccine.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:
1. If any VDH health care professional, worker or employee should be directly exposed to your child's blood or body fluids in a way that may transmit disease, I understand that the law requires my child to give a venous blood sample for further tests. I understand that the tests to be performed are for human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. 2. If your child should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the tests. I consent to such testing and the release of the test results to the person who was exposed.

Insurance*: Please answer the following:

Insurance : ( ) Uninsured
( ) Medicaid
( ) Medicare
( ) has FAMIS - FAMIS #: _____
( ) has other insurance not listed above (specify plan) _____
Policy ID # _____Policy holder's name_____

Attach a copy of the front & back of insurance card or provide the following information:
Insurance company address _____
Insurance company phone number_____

Office of Privacy and Security

Authorization for Disclosure of Protected Health Information

This consent gives the Virginia Department of Health (VDH) permission to disclose personal health information to the person(s) or organization(s) I have indicated.

- I understand the provision of treatment cannot be conditioned on my signing of this authorization.
- Any health information redisclosed by me will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included with my medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. The third party payer to pay any authorized benefits to VDH on my behalf.
- I understand this document will be given to and retained by the public health department and will not be maintained by the school.

❑ Please check box if you wish to receive a copy of the Virginia Department of Health Privacy Rights.

08/02/2021

HEALTH DEPARTMENT USE ONLY

Date	Item code	Funding Source	Lot Number	Vaccine Administration Site	Provider #
		LHD (chargeable)		RA LA	
		LHD (chargeable)		RA LA	
Comments					
Provider Name/Signature and Date					